

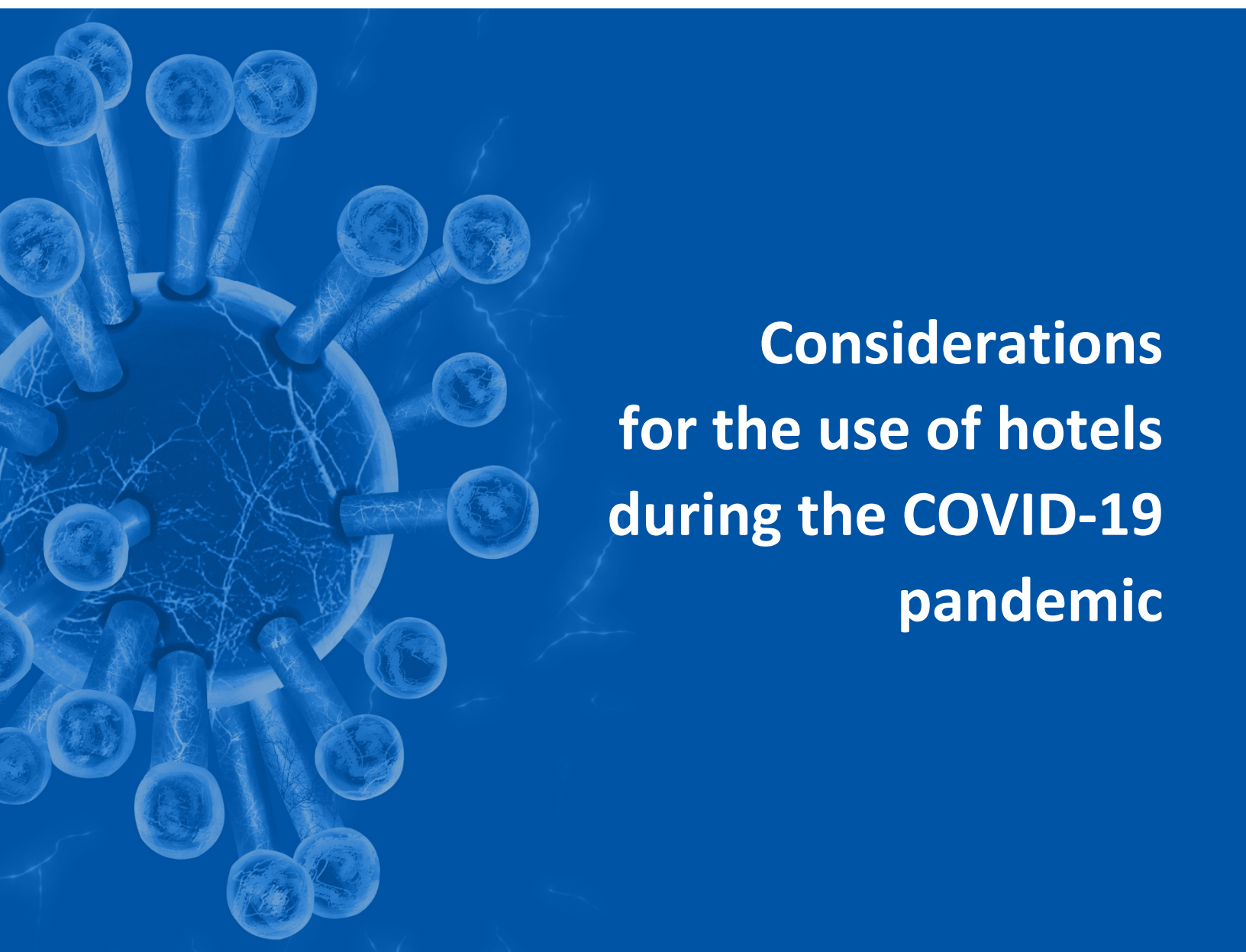
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Considerations for the use of hotels during the COVID-19 pandemic

Interim Technical Working Document - Version 5. 2 April 2020.

Considerations for the use of hotels during the COVID-19 pandemic

The COVID-19 pandemic has caused unprecedented saturation and collapse of health services around the world, requiring the implementation of strategies, not always well organized, to meet the needs resulting from a progressive increase in the demand for medical care.

The health service response starts in the community, with public education, public health and prevention measures through primary care, and coordination and linkage with hospitals.

Expanding response capacity involves strengthening primary care and providing sufficient resources at the hospital level through measures to repurpose beds, reassign health workers, early discharge of patients, among other measures.

To the extent that these health services network capacities need to be strengthened or have been overwhelmed, it is necessary to consider other strategies at the community level. One of these strategies could be fitting out hotels to be extensions of health facilities.

There are reports and case studies on the use of hotels in disasters and in the current COVID-19 pandemic, such as the example of Mexican Social Security Institute, with the recent **“Safe hotels for safe and resilient hospitals”** initiative, or the case of the Madrid hotel owners’ association (*Asociación Empresarial Hotelera de Madrid*), that has made 9,000 beds in more than 40 hotels available to the Ministry of Health to care for COVID-19 patients.

The concept of ***increase in response capacity*** of a service network describes the capacity to provide appropriate medical assessment and care given an increase in demand for health care that exceeds the limits of installed capacity, both in infrastructure and in available resources. This also includes actions by facilities to decrease the impact and maintain or rapidly recover delivery of committed health services.

An assessment of installed, contingency, and crisis capacity is the starting point for decision-making, before implementing solutions for expected needs for the response.

Emergency Levels and Readiness Actions to Increase Capacity		
Classification	Operational Definitions	Readiness Actions
1st Degree	Demand for care does not surpass the hospital services network's installed response capacity ; care can be provided with existing human resources and materials.	The strategy for the efficient use of resources is activated, if a scenario of limited resources or a progressively increasing emergency has been considered.
2nd Degree	Demand for care surpasses installed capacity, and additional human resources and materials are needed to continue providing medical services. The network of hospital-based services functions with its contingency capacity .	The hospital's emergency management system is activated: Incident Command System or Emergency and Disaster Committee. Nonessential activities, surgeries, and scheduled procedures are suspended; material and human resources are redistributed. Non-urgent admissions are suspended. The first-level or ambulatory services network should be activated.
3rd Degree	Demand for care surpasses contingency capacity; greater human and material resources and additional physical space are required to continue providing medical services. The network of hospital-based services functions with its crisis capacity .	Transfer of patients to other units is necessary. Consider early discharge or transfer to alternate locations (e.g., lower-level hospitals, hotels) of non-seriously ill or convalescent patients. All elective activities are canceled, and human and material resources are reassigned, in a resource-scarce context. Mechanisms are activated to increase staffing, through overtime, longer shifts, contracting, or subcontracting.

The decision to use an alternate site, such as a hotel, should be based on each country's administrative, legal, and decision-making context; on the current epidemiological situation of the COVID-19 pandemic; **and only when all possible alternatives in the local, regional, and national health services network have been exhausted.** This involves the efficient reorganization of hospital-based services, as well as the healthcare network, giving primary care greater response capacity. Otherwise, all the facilities, hotels, emergency medical teams, etc., will not be enough.

The purpose of this document is to provide considerations for the use of hotels, to free up physical space and specialized care capacity in health facilities, during the COVID-19 emergency, in a crisis scenario.

It does not make sense to expand a physical space if it lacks adequate human resources, supplies, and equipment, since this will only increase problems with care in the temporary facility. Non-seriously ill and stable patients can be managed in a hotel, without losing the link to the hospital, under the following circumstances:

- Take pressure off physical hospital space for repurposing of beds in health facilities to focus on unstable and higher-risk patients:

- patients who for any reason cannot return home in the short term;
 - patients who do not need intensive care, and as a result can receive care and monitoring without the need for medical equipment or technology;
 - patients who do not have an imminently life-threatening condition;
 - health workers, or reinforcements, that require temporary lodging.
- Hospital extension for COVID-19 response:
 - patients positive for COVID-19 who have mild symptoms or are asymptomatic, and the aim is to limit transmission of the disease in the family setting;
 - residents of nursing homes, day care centers, or chronic care facilities, who have been diagnosed positive for COVID-19, and have mild symptoms and low risk of complications;
 - hospitalized patients with a positive COVID-19 diagnosis that are not critically ill, have less need for care, and can be transferred to a lower complexity facility;
 - patients who, for the most part, do not need assistance with medications or activities for their daily life;
 - patients who have a **POSITIVE** COVID-19 diagnosis and do not have a home and cannot be discharged to the community.

To determine which patients qualify to be transferred to a hotel, each patient should be assessed individually. Components of infection prevention and control should be considered within the facility at all times.

The first step includes a review of the diagnosis and current status. After the initial selection of qualified patients, an in-person clinical assessment of the patient will decide whether the patient needs continuous intensive care or not or if the patient is stable enough for a lower complexity facility.

Patients who warrant transfer are classified in a cohort and are granted transfer.

Patient flow: referral to and from hotels

Locations where these patients can be referred from:

- 1) From hospitals: after a hospital stay and when the patient is in recovery.
- 2) From hospital emergency departments: when it is determined that the patient can be seen at a lower complexity facility and is stable.
- 3) From primary care: when it is detected that the patient should be seen and cared for, although does not require a higher-complexity bed.
- 4) From the community: through social organizations that provide medical triage, and can identify people living on the street that need to be cared for, but do not require a higher-complexity bed.

Locations where they can be counter-referred to:

- 1) To the hospital: with established transfer protocols, in the event their health condition worsens.
- 2) To their home: if improvement is confirmed and with primary care monitoring and follow up.
- 3) To shelters or facilities that may be available and that provide safe, decent care. Follow up by primary care.

Once the level of the emergency and the installed response capacity for the response have been assessed, and health sector authorities have considered the use of hotels as an extension of health facilities, it is recommended that the safety and quality parameters mentioned in this document be considered, to provide patients with the best possible care.

The following checklist does not replace the criteria established in the [Hospital Safety Index](#), which, when needed, can be taken as a reference to complement the assessment of structural and nonstructural safety of hotels.

General information about the hotel

Hotel name:			
Address:			
City:			
Country:			
Number of hotel employees that will continue to provide services:			
Main services	Yes	No	Comments
Kitchen			
Laundry			
Wi-Fi			
Conference room / multiple classrooms:			
Gymnasium			
Others / Specify:			
Infrastructure:			
Number of single rooms:			
Number of double rooms:			
Number of multiple rooms: (For personnel break room, sessions, coordination):			
Physical distribution: list and briefly describe services and spaces, diagram (sketch) the physical distribution of the facility's infrastructure and its surroundings. Number of floors, number of buildings			
Date of construction of the building:			
Date of structural reinforcement:			
Location	Yes	No	Comments
Ease of access			
Evidence of fire in the hotel			
Evidence of power outage			
Evidence of water cut-off			
Manager:			
Telephone and Fax:			
E-mail:			
Web page:			
Person in charge of assessment:			
Date:			



To determine how many people might be exposed.



To identify the support services available for hospital use; e.g., gymnasium for patient rehabilitation, rooms for observation wards, among others.



To identify the number of patients that can be admitted.



To establish which floors will be used, the use of lower floors is recommended to avoid unnecessary vertical transport.



To determine whether it is earthquake resistant and has "response capacity" in an earthquake.



To quickly determine whether there are hazards that could interfere with service delivery.

Checklist for the use of hotels during the COVID-19 pandemic

	Meets	Does not meet	N/A	Comments
Administrative considerations				
It has the corresponding permissions and/or certifications that enable its regular operation.				
It is located no farther than 20 km from the closest hospital.				
Administrative arrangements have been made for use of the hotel's facilities (rental, loan, etc.).				
Hotel guests have checked out.				
One of the facility's administrators and an alternate have been designated as being in charge.				
For each shift, a health professional has been designated as chief medical officer and terms of reference have been drafted.				
An infection prevention and control officer has been designated.				
A person has been put in charge of internal logistics and other functions considered necessary.				
Measures are in place to ensure the safety and wellbeing of patients and medical staff (contracting private guards, law enforcement, etc.).				
A patient registration and bed management system is in place.				
Access				
The facility allows for moving patients from one place to another (including doors that are wide enough for moving wheelchairs and gurneys).				
There is an elevator with capacity for gurney transport (the car has minimum interior dimensions of 2.20 m deep, 1.20 m wide, and 2.20 m high).				
Temporary signage (posters or other means) has been installed emphasizing the meaning of isolation and communicating to visitors whether they may enter the hotel.				
Protocols, alarms, evacuation routes, and exits are written, posted, visible, and audible. They have been evaluated by the competent authority and are in force.				
The hotel is equipped with wide band Internet and wi-fi, if possible.				
Rooms for patients				
Rooms should be private, well-ventilated, and have a toilet and shower for every patient.				
If double rooms are considered, a minimum area of 6 square meters per bed is suggested, with a well-ventilated toilet and shower.				
Design and adaptation of space				
There is an area for parking/ambulance arrivals.				
An area has been designated for patient intake, registration, and admission.				

	Meets	Does not meet	N/A	Comments
For every 30 patients, an area/room has been designated as the nursing station; it should be centrally located with respect to patients.				
A CLEAN bathing and changing room has been set up for staff use, separate from patient areas, for men and women (storage of personal protective equipment).				
A DIRTY changing room been set up for removal and disposal of personal protective equipment.				
If necessary, an area with refrigeration has been set up for medications.				
A place has been set up for equipment storage.				
A clean work area and a dirty work area with dishwasher have been set up.				
A place for temporary storage of solid waste has been set up.				
An area for clean clothes and another for dirty clothes have been set up.				
A janitor's closet with mop has been set up.				
There is an easily adaptable area for the location of essential clinical support services: sample-taking, portable X-ray, crash cart.				
Technical systems				
The hotel has a heating, ventilation, and air conditioning (HVAC) system, which receives regular maintenance.				
It has a stable source of energy input that meets the needs for electricity.				
It has an electric generator with automatic transfer.				
It has fuel for the electric generator for at least 3 days.				
The hotel's evacuation and escape routes have a lighting system.				
It has adequate lighting in all areas to be occupied.				
It has a direct connection to the water supply system (drinking water).				
It has a drinking water reserve at a rate of 300 liters per bed for 3 days.				
Water reaches all points in areas that will be occupied for medical care.				
The fire/smoke detector system works properly.				
There is a water supply for extinguishing fires.				
Portable, operational fire extinguishers are available in accordance with the needs for the type of facility.				
Waste management systems				
There is a procedure for hazardous and infectious waste management.				
Human resources				
Designate one physician and at least two nurses for every 30 patients.				
Try to have auxiliary support personnel.				

	Meets	Does not meet	N/A	Comments
Set up staff break rooms, preferably away from patient rooms.				
Establish flextime with allocated sick leave.				
Medical supplies and equipment				
Essential medical supplies have been allocated for patient care.				
Resuscitation equipment is available in case of life-threatening complications.				
Procedures and staff are available to collect, confirm, and validate data and information from the emergency.				
There is a standardized format for reporting on: emergency activity, hotel occupation, including incidence of suspected and confirmed cases, clinical situation, and deaths.				
Infection prevention and control				
The hotel has infrastructure and established procedures for proper hand hygiene, including sinks, continuing education, and available materials.				
Personal protective equipment is available, accessible, and used for/by hotel personnel when they have contact with patients or their surroundings.				
Procedures for intake and transfer of patients inside the hotel to areas set up for lodging are reviewed, updated, and tested.				
Identify at least three staff members who are always available and able to teach other health workers how to use personal protective equipment, considering additional precautions based on specific transmission mechanisms (droplets, contact, aerosols, fomites).				
There are protocols or procedures for clinical area cleanliness and hygiene that includes training on decontamination materials.				
The health facility has protocols for disinfection and sterilization of biomedical material and equipment.				
The facility has a protocol and marked handling route that ensures disposal or elimination of biological-infectious waste, including sharps and fomites.				
There are hand washing and drying stations for personnel in patient care rooms and nursing stations.				
There are enough toilets, sinks, and showers for personnel (suggested: 1 for every 15 people, divided by sex).				
There are enough toilets, sinks, and showers for patients (suggested: 1 for every 15 people, divided by sex).				
Logistics				
Transport and communication				
There is a procedure for transporting patients between the hospital and the hotel, and between the hotel and the patient's post-discharge destination.				
Patient identification cards are available that include general information, diagnosis, clinical status, classification, equipment and material necessary for transport and care, etc.				

	Meets	Does not meet	N/A	Comments
There is a telecommunications system via a call center, walkie talkies, or other means.				
Food service				
Food service is ensured through the hotel or external catering services.				
Disposable dishes and utensils are available, and a final waste disposal mechanism has been arranged.				
A staff dining area has been set up.				
There is a water purification system to ensure quality water.				
Environmental services				
Patients have a hygiene kit for two weeks (soap, shampoo, toilet paper).				
Patients are given a mask before entering the hotel and during their stay.				
Floors and surfaces are easy to clean and disinfect (avoid porous and absorbent floors, such as carpets, etc.).				
Walls and ceilings are easy to clean and disinfect.				
Laundry facilities/services				
Routine laundry is available through onsite or subcontracted washing machines and dryers.				
Access to pharmacy				
Medications are stored correctly in a designated place.				
Adequate supply of drugs and supplies.				
Medications are prepared by personnel trained in methods to prevent medication errors and contamination.				
If possible, the patients should arrive at the hotel with all medications needed for two weeks, at least.				

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